



GRETCHEN WHITMER  
GOVERNOR

STATE OF MICHIGAN  
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS  
LANSING

ORLENE HAWKS  
DIRECTOR

January 21, 2020

Krystal Walker  
Halo Home Care Services, LLC  
12 Alexander St  
River Rouge, MI 48218

RE: License #: AS820338030  
Investigation #: 2020A0782005  
Halo Home Care Services

Dear Ms. Walker:

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,

A handwritten signature in black ink that reads "Andrea L. Green". The signature is written in a cursive, flowing style.

Andrea Green, Licensing Consultant  
Bureau of Community and Health Systems  
Cadillac Pl. Ste 9-100  
3026 W. Grand Blvd  
Detroit, MI 48202  
(313) 236-0832

enclosure

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

**I. IDENTIFYING INFORMATION**

<b>License #:</b>	AS820338030
<b>Investigation #:</b>	2020A0782005
<b>Complaint Receipt Date:</b>	11/13/2019
<b>Investigation Initiation Date:</b>	11/19/2019
<b>Report Due Date:</b>	01/12/2020
<b>LicenseeName:</b>	Halo Home Care Services, LLC
<b>LicenseeAddress:</b>	12 Alexander St River Rouge, MI 48218
<b>LicenseeTelephone #:</b>	(248) 390-0388
<b>Administrator:</b>	Krystal Walker
<b>Licensee Designee:</b>	Krystal Walker
<b>Name of Facility:</b>	Halo Home Care Services
<b>Facility Address:</b>	12 Alexander St River Rouge, MI 48218
<b>Facility Telephone #:</b>	(248) 390-0388
<b>Original Issuance Date:</b>	06/21/2013
<b>License Status:</b>	REGULAR
<b>Effective Date:</b>	12/21/2019
<b>Expiration Date:</b>	12/20/2021
<b>Capacity:</b>	5
<b>Program Type:</b>	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

	ALZHEIMERS AGED TRAUMATICALLY BRAIN INJURED
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**II. ALLEGATION(S)**

	<b>Violation Established?</b>
The complainant alleged that when a staff calls off from one home the residents are transported to the other home with only one staff for all of the residents.	No
The complainant alleged that when residents are moved to a different home for the night, they do not have access to their own rooms or beds.	Yes
The complainant alleged that when residents were moved to the other home for the night, they were not given their medications as prescribed.	No

**III. METHODOLOGY**

11/13/2019	Special Investigation Intake 2020A0782005
11/19/2019	Special Investigation Initiated - Telephone Telephone call to ORR, Mr. Witcher. He stated that investigation was assigned to Edward Sims. He stated that he would forward my number to Mr. Sims.
01/06/2020	Inspection Completed On-site Interviewed staff person Reshay Purry and Residents A, B, and C.
01/06/2020	Inspection Completed-BCAL Sub. Compliance
01/06/2020	Exit Conference Exit conference call with licensee designee, Krystal Walker.

**ALLEGATION:**

The complainant alleged that when staff calls off from one home the residents are transported to the other home with only one staff for all of the residents.

**INVESTIGATION:**

I conducted an on-site investigation of this allegation on 1/6/2020. During the on-site I interviewed staff person Reshay Purry. She stated that there have been times when a staff called off or had an emergency and needed to leave when the residents from one of the Halo homes was transported to the other home. She stated that this did not happen every day but only for emergency situations. She stated this home currently has three residents and the other home has 5 residents. She stated that there is one staff providing supervision and protection to the residents.

I reviewed the licenses for this home as well as the license for the other Halo Home Care home. Each of the homes is licensed for 6 residents. Licensing rule 206 (1) states that there shall not be less than 1 direct staff to 12 residents therefore there is no violation of this licensing rule.

<b>APPLICABLE RULE</b>	
<b>R 400.14206</b>	<b>Staffing requirements.</b>
	<b>(1) The ratio of direct care staff to residents shall be adequate as determined by the department, to carry out the responsibilities defined in the act and in these rules and shall not be less than 1 direct care staff to 12 residents and children who are under the age of 12 years.</b>
<b>ANALYSIS:</b>	Each of the Halo Home Care homes is licensed for 6 residents so when combined at full capacity there would not be more than 12 residents with 1 staff present therefore violation of this rule is not established.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

**ALLEGATON:**

The complainant alleged that when residents are moved to a different home for the night, they do not have access to their own rooms or beds.

**INVESTIGATION:**

During my on-site investigation I interviewed staff person Reshay Purry regarding this allegation. She stated that on the occasions when residents have to go to the other home, they are provided with cots to sleep on. She acknowledged that the residents do not have access to their own rooms or beds when they have to stay at the other home.

I interviewed Residents A, B, and C regarding this allegation. They stated that on the occasions when they had to sleep at the other Halo home, they had a cot available to sleep on. They all stated that they do not like having to sleep at the other home because they want to sleep in their own rooms and beds at the home where they reside. They all stated that this has happened on several occasions. All of the residents stated that other than this issue they do not have any problems with their care in the home.

<b>APPLICABLE RULE</b>	
<b>R 400.14304</b>	<b>Resident rights; licensee responsibilities.</b>
	<p><b>(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:</b></p> <p style="padding-left: 40px;"><b>(p) The right of access to his or her room at his or her own discretion.</b></p>
<b>ANALYSIS:</b>	Staff person, Reshay Purry and Residents A, B, and C confirmed that the residents do not have access to their own rooms and beds during the times when they have to stay at the other Halo home.
<b>CONCLUSION:</b>	<b>VIOLATION ESTABLISHED</b>

**ALLEGATION:**

**The complainant alleged that when residents were moved to the other home for the night, they were not given their medications as prescribed.**

**INVESTIGATION:**

I interviewed staff person, Reshay Purry regarding the allegation that residents do not get their medication when they have stayed at the other Halo home. Ms. Purry stated that this is not true. She stated that the medication logs and medications are taken with them when the residents have had to stay at the other home. Ms. Purry

stated that on those occasions the residents are still given their medications as prescribed.

I interviewed Residents A, B, and C regarding this allegation. They each confirmed that they are given their medication even when the have had to stay at the other Halo home.

<b>APPLICABLE RULE</b>	
<b>R 400.14312</b>	<b>Resident medications.</b>
	<b>(2) Medication shall be given, taken, or applied pursuant to label instructions.</b>
<b>ANALYSIS:</b>	Residents A, B, and C stated that they are given their medication as prescribed even when they had to stay at the other Halo home for the night.
<b>CONCLUSION:</b>	<b>VIOLATION NOT ESTABLISHED</b>

I conducted an Exit conference call with the licensee designee Krystal Walker by telephone on 1/6/2020 to discuss the allegations. She acknowledged that there had been occasions when residents from one Halo home had been transported to the other home due to staff calling off or having to leave due to an emergency. She acknowledged that on these occasions the residents did not have access to their own rooms or beds, but she stated that cots were provided for the residents. She stated she will provide a corrective action plan to address this situation

**IV. RECOMMENDATION**

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

*Andrea L. Green*

01/14/2020

Andrea Green  
Licensing Consultant  
Approved By:

Date

*A. Hunter*

01/21/2020

Ardra Hunter  
Area Manager

Date