GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

December 19, 2022

Cajetan Kimfon
Special Care Homes L.L.C
1632 Ashby Street
Westland, MI 48186

RE: License #: AS820402241
Investigation #: 2023A0119008
Ashby A.F.C

Dear Mr. Kimfon:

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 #:	AS820402241
Investigation #:	2023A0119008
Complaint Receipt Date:	11/03/2022
Investigation Initiation Date:	11/07/2022
Report Due Date:	01/02/2023
Licensee Name:	Special Care Homes L.L.C
Licensee Address:	1632 Ashby Street Westland, MI 48186
Licensee Telephone #:	(313) 960-0934
Administrator:	Cajetan Kimfon
Licensee Designee:	Cajetan Kimfon
Name of Facility:	Ashby A.F.C
Facility Address:	1632 Ashby Street Westland, MI 48186
Facility Telephone #:	(734) 589-8891
Original Issuance Date:	04/08/2020
License **Status:**	1ST PROVISIONAL
Effective Date:	10/08/2022
Expiration Date:	04/07/2023
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS TRAUMATICALLY BRAIN INJURED DEVELOPMENTALLY DISABLED AGED

II. ALLEGATION(S)

	Violation Established?
The facility is refusing to allow Resident A to return from the hospital since 10/14/2022.	Yes

III. METHODOLOGY

11/03/2022	Special Investigation Intake 2023A0119008
11/03/2022	APS Referral Made
11/03/2022	Referral - Recipient Rights Received
11/07/2022	Special Investigation Initiated - Telephone Licensee Designee/ Administrator- Cajetan Kimfon
11/14/2022	Contact - Document Received Emergency Discharge form, four incident reports, written description of events from Mr. Kimfon
11/17/2022	Inspection Completed On-site No contact, left card
12/13/2022	Exit Conference Licensee Designee- Cajetan Kimfon
12/15/2022	Contact- Telephone call made Resident A's guardian- Paul Torony- Faith Connections Resident A's supports coordinator- Jackie Green, the Guidance Center

ALLEGATION:

The facility is refusing to allow Resident A to return from the hospital since 10/14/2022.

INVESTIGATION:

On 11/07/2022, I telephoned and interviewed Licensee Designee/ Administrator- Cajetan Kimfon regarding the above allegations. Mr. Kimfon stated he submitted an emergency discharge for Resident A prior to her going into the hospital. He stated Resident A has had three or four suicide attempts with hospitalizations. He stated Resident A's supports coordinator is aware that Resident A needed to be discharged and other placement arrangements needed to be made for Resident A.

On 11/14/2022, I received this written explanation from Mr. Kimfon regarding the above allegations:

Mr. Kimfon writes that before we took Resident A into the Ashby home, Resident A was at St. Joseph Hospital where she'd been for over five months without any home willing to consider placement. He also writes it is worth noting that Resident A has a history of suicidal attempt and hospitalization in the past prior to admission on 08/16/2022 to the Ashby Home. Mr. Kimfon's continues to write Resident A was admitted 08/16/2022 and on 09/02/2022, Resident A had the first suicide attempt and was sent to Saint Mary's Hospital. Then on 09/08/2022, Resident A had her second suicide attempt was sent to Beaumont Hospital. Then again on 09/13/2022, Resident A had her third suicide attempt and was sent to Beaumont hospital along with an adjustment in her medications. Yet again, on 10/05/2022, Resident A had her fourth suicide attempt and then transported to Garden City Hospital. It was at this time Resident A was admitted to the psychiatric ward. Mr. Kimfon stated he was in constant communication with the hospital doctors and nurses with regards to Resident A's condition. He stated that psychiatric nurses reported Resident A was violent in the hospital and had to be placed on 4-point restraints. Mr. Kimfon stated he had spoken with Jackie Green of the Guidance Center, Resident A's supports coordinator regarding the need to update Resident A's individual plan of service (IPOS) as now she will be requiring 24 hour- 1:1 staffing. He stated Ms. Green reported she had discussed with her supervisor and they all agree that Resident A will not be returning to the Ashby Home. Mr. Kimfon stated they- the Guidance Center would be pursuing other placement options for Resident A. Mr. Kimfon writes that this is a drastic change in Resident A's IPOS. Mr. Kimfon stated he does not have the staffing available to provide 1:1 support for Resident A and this puts not only Resident A at risk but also all the other residents at home.

I reviewed the emergency discharge notice that is dated for 10/06/2022 and indicates that Resident A is located at Garden City Hospital. No other placement address was provided on this notice.

On 12/15/2022, I telephoned and interviewed Resident A's guardian- Paul Torony- Faith Connections and Resident A's supports coordinator- Jackie Green, the Guidance Center regarding the above allegations. Mr. Torony stated he was aware of Resident A's numerous suicide attempts. He stated Mr. Kimfon reported that Resident A would not be able to return to the facility because they could not provide

appropriate staffing. Mr. Torony stated Mr. Kimfon requested a 24-hour discharge of Resident A.

Ms. Green stated Mr. Kimfon requested a 24-hour emergency discharge of Resident A due to not having sufficient staffing for Resident A's level of care. Ms. Green stated she is fairly new and was not aware that there is not a 24-hour emergency discharge request but rather a less than 30-day discharge request. In addition, Ms. Green stated Resident A did not have another placement arranged but was in the process of locating another placement.

APPLICABLE RULE	
R 400.14302	**Resident admission and discharge policy; house rules; emergency discharge; change of residency; restricting resident's ability to make living arrangements prohibited; provision of resident records at time of discharge.**
	(5) A licensee who proposes to discharge a resident for any of the reasons listed in subrule (4) of this rule shall take the following steps before discharging the resident: (b) The licensee shall confer with the responsible agency or, if the resident does not have a responsible agency, with adult protective services and the local community mental health emergency response service regarding the proposed discharge. If the responsible agency or, if the resident does not have a responsible agency, adult protective services does not agree with the licensee that emergency discharge is justified, the resident shall not be discharged from the home. If the responsible agency or, if the resident does not have a responsible agency, adult protective services agrees that the emergency discharge is justified, then all of the following provisions shall apply: (i) The resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located. (ii) The resident shall have the right to file a complaint with the department. (iii) If the department finds that the resident was improperly discharged, the resident shall have the right to elect to return to the first available bed in the licensee's adult foster care home.

ANALYSIS:	Based on the above information, Resident A was **not allowed to return to the facility** due to need to increase staffing. Resident A's discharge location was Garden City Hospital and an appropriate setting was **not** located to that meets the resident's immediate needs prior to discharge.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend a continuation of 1st provisional status from renewal dated 10/08/2022.

12/16/2022

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Shatonla Daniel — Date
Licensing Consultant

Approved By:

12/19/2022

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Ardra Hunter — Date
Area Manager