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GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

January 23, 2023

Carlos Eubanks
Dual Insight Npc
93 Adelaide
Detroit, MI 48202

RE: License #: AL820007537
Investigation #: 2023A0121005
Eubanks Community Living

Dear Mr. Eubanks:

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,

K. Robinson, LMSW, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-0574

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AL820007537
Investigation #:	2023A0121005
Complaint Receipt Date:	10/19/2022
Investigation Initiation Date:	10/19/2022
Report Due Date:	12/18/2022
Licensee Name:	Dual Insight Npc
Licensee Address:	93 Adelaide Detroit, MI 48202
Licensee Telephone #:	(313) 833-9141
Administrator:	Carlos Eubanks, Designee
Licensee Designee:	Carlos Eubanks, Designee
Name of Facility:	Eubanks Community Living
Facility Address:	93 Adelaide Detroit, MI 48202
Facility Telephone #:	(313) 833-9141
Original Issuance Date:	02/20/1981
License **Status:**	REGULAR
Effective Date:	07/11/2022
Expiration Date:	07/10/2024
Capacity:	17
Program Type:	DEVELOPMENTALLY DISABLED

II. ALLEGATION(S)

	Violation Established?
Unexplainable death of a resident.	No
Additional Findings	Yes

III. METHODOLOGY

10/19/2022	Special Investigation Intake 2023A0121005
10/19/2022	Special Investigation Initiated - Telephone Call to Facility; spoke to Direct Care Worker (DCW) Hilda
10/20/2022	Contact - Telephone call received Return call from Carlos Eubanks
10/20/2022	Contact - Document Received Resident A's records
11/30/2022	Contact - Telephone call received S. Daniels, assigned Licensing Consultant
01/12/2023	Contact - Telephone call made DCW Curtis Simmons
01/12/2023	Contact - Telephone call made Relative 1
01/12/2023	Contact - Telephone call made D'Shanna Watson with Detroit Wayne Integrated Health Network (DWIHN)
01/12/2023	Contact - Telephone call received Relative 2
01/12/2023	Contact - Telephone call received Rai Williams with DWIHN
01/12/2023	Contact - Document Received Resident A death certificate

01/12/2023	APS Referral Will not investigate cases involving the deceased.
01/12/2023	Referral - Recipient Rights Online
01/19/2023	Contact - Telephone call made Follow up call to Mr. Eubanks
01/20/2023	Contact - Telephone call made Wayne County Medical Examiner's Office
01/20/2023	Exit Conference Carlos Eubanks

ALLEGATION: Unexplainable death of a resident.

INVESTIGATION: On 10/20/22, I spoke to licensee designee, Carlos Eubanks. Mr. Eubanks indicated Resident A had health issues causing him to need daily blood thinner medication. Per Mr. Eubanks, Resident A did not have a 1:1 staffing assignment although he was legally "blind and very hard of hearing." Mr. Eubanks stated he was not at the facility at the time of death; he said direct care worker (DCW), Curtis Simmons was on duty. Mr. Eubanks reported he arrived at the facility after the paramedics left.

On 1/12/23, I interviewed Mr. Simmons by phone. Mr. Simmons reported Resident A woke up around 11:00 p.m. to get a glass of water out of the kitchen. Mr. Simmons said when he left to go to the bathroom, Resident A was sitting at the kitchen table finished drinking his water. Mr. Simmons explained when he returned to the kitchen, he noticed Resident A laying on the floor. According to Mr. Simmons, he originally thought Resident A had fallen onto the floor, but when he tried to help him up, Mr. Simmons noticed Resident A was not responding. Mr. Simmons said he called 911 and Mr. Eubanks to report the incident. Paramedics were not able to resuscitate Resident A. I asked Mr. Simmons if he had any indication Resident A was not feeling well or not his usual self. Mr. Simmons responded, "No." In addition, Mr. Simmons said the afternoon Staff didn't report any unusual findings at the start of his shift.

On 1/12/23, I made a phone call to Relative 1. Relative 1 acknowledged Resident A's death certificate has his cause of death listed as "something health related." Relative 1 forwarded a photocopy of the death certificate via text message and email. Resident A's cause of death is recorded as "Arteriosclerotic Cardiovascular disease." Also, Resident A's death date is recorded as 10/11/22.

Therefore, based on these findings, the department determined the licensee and those under the direction of the licensee did nothing to contribute to the death of Resident A.

APPLICABLE RULE	
R 400.15305	**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:	• The home was properly staffed with Curtis Simmons on duty. • Mr. Simmons handled the emergency by contacting 911 to send aide to the home to help resident in distress; paramedics were unable to resuscitate Resident A. • Resident A's cause of death is recorded as "Arteriosclerotic Cardiovascular disease"; therefore, the death is seemingly health related.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 11/30/22, I received notification from the assigned Licensing Consulting, Ms. S. Daniel that all residents had been removed from the home due to a bed bug infestation. Ms. Daniel said the Detroit Wayne Integrated Health Network (DWIHN) got involved after a case manager went out to the home and got bitten by a bed bug. Relative 1 and 2 reported Resident A had bed bugs on his personal belongings when they went to the home to pick up his items. On 1/12/23, I spoke with DWIHN Contract Manager, Rai Williams. Ms. Williams confirmed all residents were removed from the home last November due to a "bed bug infestation" at the home. Ms. Williams reported the agency is giving Mr. Eubanks the opportunity to remediate the situation.

On 1/20/23, I completed an exit conference with Mr. Eubanks. Mr. Eubanks confirmed 15 residents were removed from his home; he said some residents were even removed involuntarily. I asked Mr. Eubanks when he first became aware of the bed bugs and what steps had been taken to remedy the problem. Mr. Eubanks reported he'd been working with "little" pest control companies since last summer to rid the home of bed bugs. However, Mr. Eubanks indicated the bed bugs would return whenever the residents went to Day Program. According to Mr. Eubanks, the residents attended various workshops; he said they would unknowingly bring bed bugs back to the home after attending the programs. Mr. Eubanks reported he removed most of the items in the home, including furniture and carpet once the residents were removed. Mr. Eubanks stated the home received an "all clear" report from Terminix on 1/16/23; he will forward verification upon receipt of these investigative findings.

APPLICABLE RULE	
R 400.15401	**Environmental health.**
	(5) An insect, rodent, or pest control program shall be maintained as necessary and shall be carried out in a manner that continually protects the health of residents.
ANALYSIS:	• DWIHN removed all residents from Eubanks Community Living due the home being infested with bed bugs. • Mr. Eubanks acknowledged the home had a problem with bed bugs since last summer. • Therefore, the department has determined Mr. Eubanks did not maintain a pest control program that continually protected the health of residents.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

1/20/23

Kara Robinson Date

Licensing Consultant

Approved By:

1/23/23

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Ardra Hunter Date
Area Manager