GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 17, 2023

LaTosha Agee-Gussman
Carson's Adult Foster Care Inc
23650 Beech
Southfield, MI 48033

RE: License #: AM820009861
Investigation #: 2023A0121035
Carson AFC #2

Dear Mrs. Agee-Gussman:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan was required. On July 28, 2023, you submitted an acceptable written corrective action plan.

It is expected that the corrective action plan be implemented within the specified time frames as outlined in the approved plan.

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

Kara Robinson, 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 #:	AM820009861
Investigation #:	2023A0121035
Complaint Receipt Date:	06/26/2023
Investigation Initiation Date:	06/26/2023
Report Due Date:	08/25/2023
Licensee Name:	Carson's Adult Foster Care Inc
Licensee Address:	23650 Beech Rd. Southfield, MI 48033
Licensee Telephone #:	(248) 974-7988
Administrator:	LaTosha Agee, Designee
Name of Facility:	Carson AFC #2
Facility Address:	5825 Livernois Detroit, MI 48210
Facility Telephone #:	(313) 895-9012
Original Issuance Date:	N/A
License **Status:**	REGULAR
Effective Date:	05/24/2023
Expiration Date:	05/23/2025
Capacity:	11
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Resident A walked away from the facility and was later located at a local hospital. When Resident A was ready for discharge the licensee instructed the hospital to send him home in a cab, but Resident A did not arrive home as planned.	No
Additional Findings	Yes

III. METHODOLOGY

06/26/2023	Special Investigation Intake 2023A0121035
06/26/2023	Special Investigation Initiated - Telephone Office of Recipient Rights, Charles Carter
06/26/2023	Contact - Telephone call made Licensee, LaTosha Agee-Gussman
06/27/2023	Inspection Completed On-site Interviewed Resident A and B, Mrs. Agee-Gussman, and Home Manager, LaJuana Davis
07/27/2023	Contact - Telephone call made Tina Valentine, Central City
07/27/2023	Contact - Telephone call made DCW Doris Gunter
07/27/2023	Exit Conference Mrs. Agee-Gussman
07/28/2023	Corrective Action Plan Received
07/28/2023	Corrective Action Plan Approved
08/16/2023	Contact Telephone call made Follow up call to Mr. Carter, Rights Investigator

ALLEGATION: Resident A walked away from the facility and was later located at a local hospital. When Resident A was ready for discharge the licensee instructed the hospital to send him home in a cab, but Resident A did not arrive home as planned.

INVESTIGATION: On 6/27/23, I completed an onsite inspection at the facility. According to licensee designee, LaTosha Agee-Gussman, Resident A is known to go to the hospital often; it's his behavior. Mrs. Agee-Gussman explained the hospital contacted her on 6/20/23 to report Resident A was ready for discharge. Mrs. Agee-Gussman admitted she asked the hospital worker to send him home in a cab because the agency van had a flat tire. The hospital agreed. Because Resident A likes to go back and forth to the hospital, Mrs. Agee-Gussman reported it is not uncommon for him to be returned home by cab. However, Resident A did not return home at the scheduled drop-off time. When Home Manager, LaJuana Davis made a follow-up call to the hospital, the hospital confirmed Resident A was sent home around 8:37 a.m. Ms. Davis said Resident A was missing until 2:00 a.m. the following morning. It was later discovered Resident A had spent the night with his girlfriend. The home has no information pertaining to the girlfriend.

Resident A told me he left the house to clear his head. Resident A indicated he left on his own free will. Per Mrs. Agee-Gussman, Resident A does not have a 1:1 Staffing assignment, so he is allowed to go in the community independent of Staff.

On 7/27/23, I completed an exit conference with Mrs. Agee-Gussman; she agrees with the department's findings related to this incident.

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 A went to the hospital on his own free will. Instead of returning home as planned, Resident A opted to thwart the plan and spend time with his girlfriend. • Resident A returned home unharmed. • Mrs. Agee-Gussman arranged to have Resident A returned home safely to no avail. • There is insufficient evidence to suggest the licensee failed to protect Resident A.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: Resident A reported he left the home to clear his head because Ms. Davis humiliated him. Resident A reported he needed to see a doctor because he started feeling depressed after Ms. Davis hit him. Resident A reported Ms. Davis kicked him in the hip and grabbed his face by the cheek. Ms. Davis admitted to kicking Resident A, but she said she did so in self-defense. Ms. Davis stated Resident A attacked her as they headed outside for a smoke break. According to Ms. Davis, Resident A was seemingly agitated because he wanted to smoke prior to the designated smoke break. Ms. Davis explained Resident A turned around and attacked her out of nowhere as the group was going downstairs to the front door. Ms. Davis said as Resident A began to scratch her, she "kicked at him and pushed him out the door." Ms. Davis was adamant that she only reacted that way to "protect" herself. For clarity, I repeated, "You kicked him?" and Ms. Davis replied, "Yea because I had to get him off me in that little space", referring to the stairwell. Ms. Davis reported the incident is isolated and that Resident A has never attacked her before. It should be noted, Mrs. Agee-Gussman was present for the interview. Resident B reported he witnessed the whole incident. Resident B said he did not see Resident A scratch Ms. Davis; however, he did see Ms. Davis grab Resident A by his hood to prevent the resident from leaving the premises. Resident B reasoned "it doesn't make sense that she would stop him from going outside if she were being attacked." Resident B abruptly ended our interview stating he wanted to "stay out of it" and have nothing more to do with the investigation.

On 7/27/23, I completed an exit conference with Mrs. Agee-Gussman. I reported the additional finding to Mrs. Agee-Gussman. I explained that Ms. Davis should be held to a higher standard since she's the home manager. I reiterated to Mrs. Agee-Gussman that resident abuse is not allowed under no circumstances in accordance with the Administrative Rules. Mrs. Agee-Gussman submitted an acceptable plan of correction to the department on 7/28/23. Mrs. Agee-Gussman permitted Ms. Davis to maintain her position as Home Manager with the understanding that resident abuse will not be tolerated.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(1) A licensee shall not mistreat a resident and shall not permit the administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home to mistreat a resident. Mistreatment includes any intentional action or omission which exposes a resident to a serious risk or physical or emotional harm or the deliberate infliction of pain by any means.

ANALYSIS:	• Resident A reported Ms. Davis kicked him and grabbed his face. • Resident B observed Ms. Davis grab Resident A by the hood of his clothes. • Ms. Davis admitted to physically managing Resident A.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

An acceptable corrective action plan has been received; therefore, I recommend the status of this license remain unchanged.

8/16/23

Kara Robinson — Date
Licensing Consultant

Approved By:

8/17/23

Ardra Hunter — Date
Area Manager