GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

August 16, 2023

Aba Hayford
Trinity Blessings LLC
PO Box 3605
Saginaw, MI 48605

RE: License #:	AS730403466
Investigation #:	2023A0123055
	Trinity Blessings

Dear Aba Hayford:

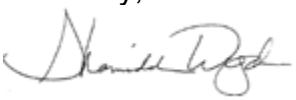
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

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 (517) 643-7960.

Sincerely,



Shamidah Wyden, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48607
989-395-6853

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS730403466
Investigation #:	2023A0123055
Complaint Receipt Date:	07/03/2023
Investigation Initiation Date:	07/05/2023
Report Due Date:	09/01/2023
Licensee Name:	Trinity Blessings LLC
Licensee Address:	3084 Janes St Saginaw, MI 48601
Licensee Telephone #:	(989) 270-1250
Administrator:	Aba Hayford
Licensee Designee:	Aba Hayford
Name of Facility:	Trinity Blessings
Facility Address:	650 Weadock Saginaw, MI 48607
Facility Telephone #:	(989) 501-3882
Original Issuance Date:	11/06/2020
License Status:	REGULAR
Effective Date:	11/06/2021
Expiration Date:	11/05/2023
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
On 06/29/2023, staff Shelly House was observed opening the lift gate to her vehicle. Staff House had Resident B get into the vehicle to sit in the storage area, while the other residents sat on the seats with seatbelts.	Yes

III. METHODOLOGY

07/03/2023	Special Investigation Intake 2023A0123055
07/03/2023	APS Referral APS referral information received.
07/05/2023	Special Investigation Initiated - Telephone I spoke with Complainant 1 via phone.
07/11/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility. There was no answer at the door. No one appeared home.
07/19/2023	Inspection Completed On-site I conducted an unannounced on-site at the facility.
07/24/2023	Contact - Telephone call made I spoke with co-owner Laticia King via phone.
08/16/2023	Contact- Telephone call made I made a follow-up call to Complainant 1.
08/16/2023	Contact- Telephone call made I made a follow-up call to Staff Shelly House.
08/16/2023	Exit Conference I spoke with licensee designee Aba Hayford via phone.

ALLEGATION: On 06/29/2023, staff Shelly House was observed opening the lift gate to her vehicle. Staff House had Resident B get into the vehicle to sit in the storage area, while the other residents sat on the seats with seatbelts.

INVESTIGATION: On 07/05/2023, I spoke with Complainant 1 via phone. Complainant 1 reported the following:

It is unknown how many residents were in the vehicle, but six residents currently reside in the home. It is believed that the vehicle is Staff Shelly House's personal vehicle, and it is assumed Staff House uses her personal vehicle to transport residents. The home is staffed with one staff per shift. Resident B has a public guardian. The residents are picked up from program between 3:00 pm and 3:30 pm. Resident B is verbal, but difficult to understand. Resident C speaks clearly but is blind.

On 07/11/2023, I conducted an unannounced on-site at the facility. There was no one home, and no answer at the door.

On 07/19/2023, I conducted a follow-up unannounced on-site at the facility. I interviewed staff Shelly House. Staff House denied the allegations. She stated that one resident sits in the front seat. Two others sit in the back seat including Resident B. Staff House stated that only three residents get picked up from the program that Resident B attends.

During this on-site, I attempted to interview Resident B. Resident B appeared to be limited verbally. Resident B and I walked to Staff House's vehicle parked on the side of the house. I asked Resident B where he sits in the vehicle when getting picked up from program and if he has ever ridden in the rear cargo space. Resident B began moving items around in the cargo space of the vehicle to sit inside of it. Due to difficulty understanding Resident B's verbal responses, I asked again where he sits in the vehicle. He reported that he sits in the middle of the back row of seats. Resident B pointed this out as well.

On 07/24/2023, I interviewed co-owner Laticia King via phone. Laticia King denied the allegations stating that Staff House nor Resident B would ever do this. She stated that Staff House is very hands on and always has does things in the residents best interests.

On 07/24/2023, I spoke with Guardian 1, Resident B's public guardian via phone. Guardian 1 stated that Resident B attends a day program that is less than one mile from the AFC home. Staff House picks up and drops off Resident B. The vehicle only has four belted positions. There are concerns about safety, because Staff House does not have other staff, and has to take other residents to go and pick up Resident B. Guardian 1 was informed that Resident B had to enter the vehicle through the rear hatch. Resident B is usually honest, and relatively accurate, but might tell you what you want to hear. Resident B is very smart with a good memory.

On 08/16/2023, I made a follow-up call to staff Shelly House. Staff House reported the following:

Resident A goes to a day program. The day program picks him up and drops him off at the facility.

Resident B, Resident C, and Resident D, and Resident E go to a second day program. Staff House provides the transportation to and from their program.

Resident F attends a third program. Resident F's program picks Resident F up and drops him off at the facility.

On 08/16/2023, I spoke with Complainant 1 and Individual 1 via phone. They reported that there are four residents that staff Shelly House provides transportation for. Resident B was seen getting into the rear hatch/cargo area of Staff House's vehicle at least a couple of times since after this investigation began. Resident B has not been observed getting in the rear cargo space of the vehicle in the last two weeks. There is video evidence of Resident B getting in the rear cargo space of the vehicle.

During this call, I received video via text message that shows Staff Shelly House with Resident B, Resident C, Resident D, and Resident E entering Staff House's vehicle. The video is dated 06/29/2023. Resident B is clearly observed walking to, then sitting inside the rear cargo space with his legs crossed, and Staff House closing the hatch door. There were two residents in the back passenger seats, and one in the front passenger seat. Complainant 1 and Individual 1 stated that this has happened multiple times.

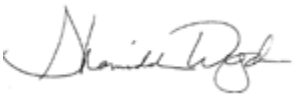
APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Complainant 1 and Individual 1 reported witnessing Staff Shelly House transporting residents in her personal vehicle, with Resident B entering the vehicle through the rear hatch and sitting in the cargo space area of the vehicle. On 07/19/2023, staff Shelly House denied the allegations and stated that only three residents are transported by her to and from program.

	On 08/16/2023, Staff House reported that four residents are transported by her to and from program. Guardian 1 reported being informed that Resident B was observed sitting in the rear cargo space of Staff House's vehicle. Video evidence obtained on 08/16/2023, dated 06/29/2023, confirms that Resident B sat in the cargo space of the vehicle, while three other residents sat in belted seats. There is a preponderance of evidence to substantiate a rule violation in regard to Resident B riding in a motor vehicle, not sitting in a belted position.
CONCLUSION:	**VIOLATION ESTABLISHED**

On 08/16/2023, I conducted an exit conference with licensee designee Aba Hayford. I informed her of the findings and conclusion of this report.

IV. RECOMMENDATION

Contingent upon the receipt of an acceptable corrective action plan, I recommend continuation of this AFC small group home license (capacity 6).



08/16/2023

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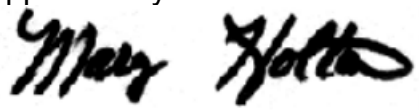
Shamidah Wyden Date
Licensing Consultant

Approved By:



08/16/2023

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Mary E. Holton Date
Area Manager