GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 7, 2024

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

RE: License #: AS820338030
Investigation #: 2024A0901039
Halo Home Care Services

Dear Krystal Magee:

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,

Regina Buchanan, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 949-3029

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820338030
Investigation #:	2024A0901039
Complaint Receipt Date:	06/20/2024
Investigation Initiation Date:	06/21/2024
Report Due Date:	08/19/2024
Licensee Name:	Halo Home Care Services, LLC
Licensee Address:	12 Alexander St River Rouge, MI 48218
Licensee Telephone #:	(248) 390-0388
Administrator:	Krystal Magee
Licensee Designee:	Krystal Magee
Name of Facility:	Halo Home Care Services
Facility Address:	12 Alexander St River Rouge, MI 48218
Facility Telephone #:	(248) 390-0388
Original Issuance Date:	06/21/2013
License Status:	REGULAR
Effective Date:	12/21/2023
Expiration Date:	12/20/2025
Capacity:	5
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED

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II. ALLEGATION(S)

	Violation Established?
There are seven residents, and the home is only licensed for five.	Yes
Resident A has a history of cutting herself. Staff, Latoya, stated, “I don't give a fuck if you go cut yourself.”	No

III. METHODOLOGY

06/20/2024	Special Investigation Intake 2024A0901039
06/20/2024	APS Referral Complainant
06/21/2024	Special Investigation Initiated - Telephone Home Manager Resident A
06/21/2024	Contact - Telephone call received Staff, Latoya Johnson
07/01/2024	Referral - Recipient Rights
07/01/2024	Contact - Telephone call made Resident A’s Guardian
07/25/2024	Exit Conference Licensee designee, Krystal Magee
08/07/2024	Inspection Completed-BCAL Sub. Compliance

ALLEGATION:

Resident A has a history of cutting herself. Staff, Latoya, stated "I don't give a fuck if you go cut yourself."

INVESTIGATION:

On 06/21/2024, I made a telephone call to the facility and interviewed the home manager, Reshay Purry. She stated she did not know anything about the allegations, and this was her first time hearing them. She also stated Resident A has a history of cutting herself and running off from the facility. Reshay identified the staff as Latoya Johnson and gave me her contact information.

On 06/21/2024, during my telephone call with Reshay, Resident A was present at the facility, and I interviewed her. She stated the incident happened in May 2024 and that she has not had anymore issues with Latoya since then. Resident A explained that she cuts herself a lot and had threatened to cut herself that day. She said Latoya made the comment because staff gets tired of calling the police and making reports. She reported there were no witnesses and denied telling Reshay or the licensee designee, Krystal Magee.

On 06/21/2024, I received a telephone call from Latoya. She denied encouraging Resident A to cut herself and stated she would never use profanity toward the residents. She recalled having a conversation with Resident A during the month of May 2024, in which she cautioned her about cutting herself, telling her she may risk cutting the wrong thing.

On 07/01/2024, I made a telephone call to Resident A's guardian. She stated Resident A has a long history of cutting herself, going to the hospital, and fabricating. Whenever she is feeling anxious or not getting her way, she cuts on herself to get out of the home. Resident A's guardian doubted the validity of the allegations and stated the staff provides really good care and has been trying really hard to work with Resident A. Resident A's guardian also said Resident A never mentioned the allegations to her, even though she maintains contact with her and just recently saw her.

On 07/25/2024, I conducted an exit conference with Krystal. She agreed with my investigative findings. She stated Resident A never complained to her about Latoya verbally mistreating her. Krystal stated the allegations did not surprise her because Resident A complains about everything and everyone.

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:	Based on the information obtained during this investigation, there is a lack of evidence to support the allegations. I'm unable to corroborate that Resident A was not treated with dignity and her protection and safety was not attended to. Although she indicated the allegations are true, Latoya denied the allegations. In addition to this, Resident A's guardian indicated Resident A has a long history of fabricating.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

There are seven residents, and the home is only licensed for five.

INVESTIGATION:

On 06/21/2024, I made a telephone call to the facility and interviewed Resident A. She stated there are sometimes six or seven people in the facility. She explained that the owner has another AFC facility and sometimes the residents from that facility spends the night at the above facility.

On 06/21/2024, I received a telephone call from staff, Latoya Johnson. She indicated that three people live in this facility but sometimes there are seven residents total. Latoya explained that at times, due to staffing issues, the ladies at the other house must spend the night there.

On 07/25/2024, I conducted an exit conference with the licensee designee Krystal Magee. She stated staff should not be having the ladies from the other facility spend the night and that should talk with them about this.

APPLICABLE RULE	
R 400.14105	**Licensed capacity.**
	(3) The total number of occupants shall not be more than 6 over the licensed capacity.

ANALYSIS:	Based on the information obtained during this investigation, occasionally the total number of occupants of the home is more than the licensed capacity. Latoya and Resident A confirmed that the residents from Krystal's other facility sometimes spend the night at this facility, which takes the home's licensed capacity over five.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

08/07/2024

Regina Buchanan — Date
Licensing Consultant

Approved By:

08/07/2024

Ardra Hunter — Date
Area Manager