GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

January 8, 2025

Latoya Ferrell
13678 Country Walk Blvd
Belleville, MI 48111

RE: License #: AS820406563
Investigation #: 2025A0101002
Amagine AFC

Dear Ms. Ferrell:

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,

Edith Richardson, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 919-1934

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820406563
Investigation #:	2025A0101002
Complaint Receipt Date:	10/14/2024
Investigation Initiation Date:	10/15/2024
Report Due Date:	12/13/2024
Licensee Name:	Latoya Ferrell
Licensee Address:	13678 Country Walk Blvd Belleville, MI 48111
Licensee Telephone #:	(734) 624-8072
Administrator:	N/A
Licensee Designee:	Latoya Ferrell
Name of Facility:	Amagine AFC
Facility Address:	19491 Beaverland St. Detroit, MI 48219
Facility Telephone #:	(734) 578-7693
Original Issuance Date:	03/08/2022
License **Status:**	REGULAR
Effective Date:	09/08/2024
Expiration Date:	09/07/2026
Capacity:	4
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL ALZHEIMERS

	AGED

II. ALLEGATION(S)

	Violation Established?
Direct care staff are not trained.	No
The licensee changed the residency of the residents to her personal home without the written approval from their designated representative.	Yes
Resident A appeared malnourished and had sores on her legs.	No
The residents were relocated because the roof was leaking.	No

III. METHODOLOGY

10/14/2024	Special Investigation Intake 2025A0101002 Anonymous
10/15/2024	Special Investigation Initiated – Telephone Latoya Ferrell, licensee designee
10/18/2024	Inspection Completed On-site Unannounced No answer
10/18/2024	Contact – Telephone call made Amagine AFC Home Jacquline Harris direct care, staff is not at the AFC home. There is only one resident residing in the home and she is visiting with her family.
10/22/2024	Telephone call made Ms. Ferrell
10/25/2024	Inspection Completed On-site No answer
10/25/2024	Contact – Telephone call made Ms. Ferrell, direct care staff is not at the AFC home, Relative A did not return Resident A to group home
11/01/2024	Inspection Completed On-site Physical plant inspection

11/06/2024	Contact – Document received Additional allegation received Anonymous
12/05/2024	Contact – Telephone call made Ms. Ferrell
12/12/2024	Contact – Document Received ID sheets
12/20/2024	Contact – Telephone call made Relative B
12/20/2024	Contact – Telephone call made Ms. Ferrell
12/26/2024	Contact – Telephone call made Relative A
12/26/2024	Contact – Telephone call made Witness 1
12/26/2024	Contact – Telephone call made Tone Home Health Care Services
12/26/2024	Contact – Document sent Tone Home Health Care Services
12/26/2024	Contact – Document received Tone Home Health Care Services William Tolentino
12/26/2024	Exit conference Ms. Ferrell
12/27/2024	APS referral made
01/01/2025	Contact – Document received Ms. Harris' training

ALLEGATION: Direct care staff are not trained.

INVESTIGATION: On 10/15/2024, I spoke with Ms. Ferrell. Ms. Ferrell denied the allegation that direct care staff (DCS) are not trained. Ms. Ferrell stated she and one

other person provide the required 24 hours staffing. Ms. Ferrell stated Jacquline Harris is her only staff and the assigned licensing consultant reviewed her employee file on 09/04/2024, during the renewal inspection.

On 12/05/2025, I requested copies of Ms. Harris' training. On 01/03/2025, I reviewed copies of Ms. Harris' training. Ms. Harris' training was in compliance with licensing requirements.

On 12/26/2024, I conducted an exit conference with the licensee, Ms. Ferrell. Ms. Ferrell agrees with my finding.

APPLICABLE RULE	
R 400.14204	**Direct care staff; qualifications and training.**
	(3) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be competent before performing assigned tasks, which shall include being competent in all of the following areas: (a) Reporting requirements. (b) First aid. (c) Cardiopulmonary resuscitation. (d) Personal care, supervision, and protection. (e) Resident rights. (f) Safety and fire prevention. (g) Prevention and containment of communicable diseases.
ANALYSIS:	The licensee provided training to her DCS, Ms. Harris. On 01/03/2024, I reviewed Ms. Harris' training.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The licensee changed the residency of the residents to her personal home without the written approval from their designated representative.

INVESTIGATION: On 10/14/2024, and on 11/06/2024, an anonymous complaint was filed with the AFC Licensing Division regarding the Amagine AFC Home. The Amagine AFC home is private pay, and no responsible agencies are involved.

On 10/15/2024, I spoke with the licensee, Latoya Ferrell. Ms. Ferrell denied the allegations. Ms. Ferrell stated Resident A's daughter is angry because she had to move her mother. Ms. Ferrell stated Resident A became non-ambulatory while

residing in her home. Ms. Ferrell further stated since the home is not wheelchair accessible Resident A needed to be moved. According to Ms. Ferrell, Resident A's daughter "begged" her to keep her mother. Ms. Ferrell stated she told Resident A's daughter that she could not keep Resident A because it would put her license in jeopardy. Ms. Ferrell stated Resident A was discharged on 10/14/2024.

On 12/20/2024, I spoke with Resident B's daughter. Relative B stated that Ms. Ferrell changed her mother's location from the group home to her personal home. Relative B stated on 01/01/2024, she received a phone call from Ms. Ferrell stating that there was a lot of gun shots near the group home on New Year Eve. Therefore, Ms. Ferrell took her mother to her private home.

On 12/26/2024, I spoke with Resident A's daughter. Resident A's daughter stated she learned that her mother had been moved to Ms. Ferrell private home when she went to the Amagine AFC home in July and her mother was not there. Resident A's daughter admitted she allowed her mother to stay at Ms. Ferrell's home until she was discharged.

On 12/26/2024, I received written documentation from Tone Home Health Care Services Representative, Williams Tolentino. Mr. Tolentino stated that Resident A received services from the care team at Ms. Ferrell's private address. According to Mr. Williams the care team provided services to Resident A at Ms. Ferrell's private home from July 2024, until the middle of October 2024.

On 12/26/2024, I spoke with Witness 1. Witness 1 stated Residents A and B resided at Ms. Ferrell's home off and on throughout the year. Witness 1 stated that she visited Residents A and B at Ms. Ferrell's private home.

On 12/26/2024, I spoke with Ms. Ferrell. I shared my findings with Ms. Ferrell. Ms. Ferrell stated that the designated representatives knew she moved Residents A and B into her private home. Ms. Ferrell stated she did not have written documentation to change Residents A's and B's residency from one home to another.

On 12/26/2024, I conducted an exit conference with the licensee, Ms. Ferrell. Ms. Ferrell did not dispute my findings.

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.**
	(6) A licensee shall not change the residency of a resident from one home to another without the written approval of the resident or the resident's designated representative and responsible

	agency.
ANALYSIS:	Ms. Ferrell changed the residency of residents from one home to another without written approval of the designated representatives. On 12/26/2024, I spoke with Ms. Ferrell. I informed Ms. Ferrell of my findings, Relative A, Relative B, Witness 1 and the Tone Home Health Care Team all stated she had moved Resident A and Resident B to her private home. Ms. Ferrell stated she did not have written documentation to change Residents A's and B's residency from one home to another.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A appeared malnourished and had sores on her legs.

INVESTIGATION: On 12/26/2024, I spoke with Relative A. Relative A stated her mother is living with her and is doing well. However, she developed a sore on her foot when she was in Ms. Ferrell's home. Relative A sent me two pictures of a foot with what appears to be a blister on it. There is no way for me to determine whose foot it is in the pictures and when the pictures were taken.

On 12/26/2024, I spoke with Witness 1. Witness 1 stated when she visited Residents A and B at the group home they did not seem right. Witness 1 stated they were in the bed during the middle of the day and no food was being prepared.

On 12/26/2024, I received written documentation from Tone Home Health Care Services' Representative Williams Tolentino. Mr. Tolentino stated that Resident A is a patient with them. According to Mr. Tolentino the care team are mandated reporters and by law they are obligated to report neglect and abuse.
On 12/26/2024, I conducted an exit conference with the licensee, Ms. Ferrell. Ms. Ferrell agrees with my finding.

APPLICABLE RULE	
R 400.14305	(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 upon the preponderance of evidence there is insufficient evidence to determine the licensee did not meet the residents' personal needs at all times. According to Mr. Tolentino, Resident A is a patient with Tone Home Health Care Services**.** Mr. Tolentino stated the care team are mandated reporters and by law they are obligated to report neglect and abuse.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: The residents were relocated because the roof was leaking.

INVESTIGATION: On 10/18/2024, I conducted an unannounced inspection. Upon arrival I called the facility's phone number. I spoke with direct care staff Jacquline Harris. Ms. Harris stated that no one was at the home. According to Ms. Harris, the home only has one resident, and she went on a visit with her family.

On 10/18/2024, I observed the roof from the outside of the home. Since no one was at home I was unable to observe the inside of the home. The roof appeared to me to be in good condition.

On 11/01/2024, I conducted a physical plant inspection. The home appeared unoccupied. I did not observe any clothing. I also did not observe any water damaged due to a worn roof. The ceilings and walls were intact. There was no standing water or water lines along the walls in the basement. The home furnishing and housekeeping standards were clean and orderly.

On 12/26/2024, I conducted an exit conference with the licensee. Ms. Ferrell agrees with my findings.

APPLICABLE RULE	
R 400. 14403	(4) A roof, exterior walls, doors, skylights, and windows shall be weathertight and watertight and shall be kept in sound condition and good repair.
ANALYSIS:	The home's roof is in sound condition and good repair. On 10/18/2024, I observed the roof to be in good condition. On 10/25/2024, I did not observe any water damage inside of the facility.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

Edith Richardson
Licensing Consultant

01/07/2024
Date

Approved By:

01/08/2025

Ardra Hunter
Area Manager

Date