GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 11, 2025

Delphine Higgins
Tend2Care LLC
16766 Beech Daly Rd.
Redford, MI 48240

RE: License #: AS820410926
Investigation #: 2025A0121011
Tend2Care I

Dear Mrs. Higgins:

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.

A six-month provisional license is recommended. If you do not contest the issuance of a provisional license, you must indicate so in writing; this may be included in your corrective action plan or in a separate document. If you contest the issuance of a provisional license, you must notify this office in writing and an administrative hearing will be scheduled. Even if you contest the issuance of a provisional license, you must still submit an acceptable corrective action plan.

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.

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, MSW, 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 #:	AS820410926
Investigation #:	2025A0121011
Complaint Receipt Date:	01/02/2025
Investigation Initiation Date:	01/03/2025
Report Due Date:	03/03/2025
Licensee Name:	Tend2Care LLC
Licensee Address:	16766 Beech Daly Rd. Redford, MI 48240
Licensee Telephone #:	(131) 338-4692
Administrator:	Delphine Higgins
Licensee Designee:	Delphine Higgins
Name of Facility:	Tend2Care I
Facility Address:	16765 Beech Daly Rd. Redford, MI 48240
Facility Telephone #:	(313) 627-7949
Original Issuance Date:	05/25/2023
License **Status:**	REGULAR
Effective Date:	11/25/2023
Expiration Date:	11/24/2025
Capacity:	3
Program Type:	PHYSICALLY HANDICAPPED MENTALLY ILL AGED

II. ALLEGATION(S)

	Violation Established?
Residents left home alone on repeat occasions without any staff to care for them.	Yes
On 12/30/24, Delphine Higgins physically guided Resident A to her room despite the resident refusing to go. Resident A alleges Mrs. Higgins pushed and shoved her forcibly. Resident A has been emotionally and physically abused at the facility.	Yes
There is no landline phone available, and the residents do not have access to cell phones to call for help in cases of emergency.	Yes
Home has bed bugs.	No
Additional Findings	Yes

III. METHODOLOGY

01/02/2025	Special Investigation Intake 2025A0121011
01/03/2025	Special Investigation Initiated - On Site Onsite inspection completed by Licensing Consultant, E. Richardson for K. Robinson. Interviewed licensee designee, Delphine Higgins.
01/14/2025	Inspection Completed-BCAL Sub. Non-Compliance Interviewed Resident A - B and Mrs. Higgins.
01/15/2025	Contact - Telephone call made Follow up call to Mrs. Higgins
01/16/2025	Contact - Document Received Email from Mrs. Higgins (IPOS and Assessments requested)
01/24/2025	Contact - Telephone call received Annette Bearden with Adult Protective Services (APS)
01/24/2025	APS referral

01/31/2025	Contact - Telephone call made Mrs. Higgins
01/31/2025	Contact - Telephone call made Guardian A
01/31/2025	Contact - Telephone call made Dempster Yallah and Sarah Brookins with Lincoln Behavioral Services
02/03/2025	Contact - Document Sent Redford PD Records Dept.
02/04/2025	Contact - Document Received Police report from Redford PD
02/05/2025	Contact - Telephone call made Follow up call to Ms. Bearden with APS
02/05/2025	Contact - Telephone call made Direct care staff, Nehemiah Barnes
02/05/2025	Contact - Telephone call made Direct care staff, Tequina Moore
02/06/2025	Contact - Telephone call received Ofc. Joe Haapala with Redford PD
02/07/2025	Contact - Telephone call made Mrs. Higgins
02/07/2025	Contact - Telephone call made Guardian C
02/26/2025	Exit Conference Mrs. Higgins

ALLEGATION: Residents left home alone on repeat occasions without any staff to care for them.

INVESTIGATION: On 1/3/25, Licensing Consultant, E. Richardson initiated the complaint onsite. Mrs. Richardson met with licensee designee, Delphine Higgins. I conducted a follow up inspection at the facility on 1/14/25 at approximately 2:38 PM. This inspection was unannounced. I knocked on the door and heard an occupant

ask, “Who is it?” I identified myself with the “State of Michigan.” The occupant asked that I identify myself again, so I repeated, “State of Michigan.” Then, there was silence. I contacted Mrs. Higgins as I waited outside the facility. Mrs. Higgins confirmed I had the correct address. I asked Mrs. Higgins if she was at the facility and she responded, “Yes, I’m here working.” That’s when I directed Mrs. Higgins to open the door because I was waiting outside to enter the home. Mrs. Higgins responded, “Okay.” However, Mrs. Higgins still did not answer the door. I observed Mrs. Higgins arrive by vehicle approximately 10 minutes later.

When I entered the home, I observed 4 residents in care. There was no staff on duty besides Mrs. Higgins. Mrs. Higgins acknowledged that she left Resident A-D home alone. According to Mrs. Higgins, she went to a nearby Dollar Tree to purchase toilet tissue because they had run out. Mrs. Higgins argued that she installed a camera in the dining room to monitor residents. Mrs. Higgins showed no remorse for her actions as she stated, “Sometimes I have to leave … I got to do, what I go to do!”

I interviewed Resident A and B. Resident B was identified as the voice behind the door. When asked, why she didn’t open the door, Resident B became hostile, yelling, “Because I don’t know you!” It was apparent that Resident B was feeding off Mrs. Higgins’ aggression by joining in the hostile behavior. Resident A reported Mrs. Higgins leaves them home alone often. Specifically, Resident A reported residents are left home alone “everyday … for hours.”

On 2/1/25, I reviewed Resident A-D’s most recent AFC Assessment Plans and treatment plans. Resident A-D suffer from a range of conditions, including but not limited to, mental illness, cognitive impairments, and physical disabilities. Resident A-D require supervision 24 hours per day.

On 2/5/25, I interviewed direct care staff, Nehemiah Barnes and Tequina Moore. Ms. Barnes indicated she stopped working at the facility on a regular basis 4-5 months ago. According to Ms. Barnes, Mrs. Higgins “just didn’t have the work.” Now Ms. Barnes said she works on-call roughly 1-2 times per month. Ms. Moore said she works Mondays, Fridays, and Sundays 8:30 AM – 8:00 PM.

On 2/26/25, I completed an exit conference with Mrs. Higgins. Mrs. Higgins continued to reason that Resident B is “high functioning”, so she determined Resident B was suitable to supervise the home in the absence of staff. In fact, Mrs. Higgins suggested the administrative rules be revised to allow the use of cameras in AFC homes.

APPLICABLE RULE	
R 400.14206	**Staffing requirements.**
	(2) A licensee shall have sufficient direct care staff on duty at all times for the supervision, personal care, and protection of residents and to provide the services specified in the resident's resident care agreement and assessment plan.
ANALYSIS:	On 1/14/25, Mrs. Higgins left 4 vulnerable adults at the facility unsupervised for an unknown period. Mrs. Higgins' actions were willful and substantial. Also, Resident A stated residents are left home alone on a regular basis.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: On 12/30/24, Delphine Higgins physically guided Resident A to her room despite the resident refusing to go. Resident A alleges Mrs. Higgins pushed and shoved her forcibly. Resident A has been emotionally and physically abused at the facility.

INVESTIGATION: On 1/3/25 and 1/14/25, Mrs. Higgins acknowledged that she "guided" Resident A to her bedroom after the resident refused to leave the area. Mrs. Higgins explained Resident B experienced a medical emergency, so Mrs. Higgins called emergency medical services to come to the home. According to Mrs. Higgins, Resident A was on the phone sharing details of what was happening in the home with her loved one. In addition, Mrs. Higgins reported Resident A was simply in the way, so she directed the resident to stop sharing private information and "go to her room." When Resident A refused to leave the area, Mrs. Higgins stated, "I walked over and guided her to her room." I asked Mrs. Higgins to demonstrate how she "guided her to her room", and she hooked her arm under mine and gently pulled me toward the direction she wanted me to go. Mrs. Higgins denied using force with Resident A; however, Mrs. Higgins reported Resident A was screaming, "I'm killing her!"

On 1/14/25, I interviewed Resident A onsite. Resident A reported Mrs. Higgins grabbed her so tight that she left a handprint on her body (hand). Resident A also reported Mrs. Higgins tends to "boss me around." I was unable to interview the other residents in the home. Resident B was determined uncooperative due to the aggression and rage she displayed. Resident C and D have severe cognitive impairments; therefore, they could not actively participate in an interview.

On 12/30/24, Redford PD was notified about the incident. Officer Joe Haapala arrived on scene. On 2/6/25, I interviewed Officer Haapala by phone. Officer

Haapala verified he was called to the home to investigate a possible assault case. When he arrived on scene, he interviewed both Mrs. Higgins and Resident A. Officer Haapala indicated that although he did not observe any marks or injuries on Resident A, Mrs. Higgins displayed an “aggressive tone and temperament.” Officer Haapala described Mrs. Higgins as “not the most professional” citing she had an “overall attitude … and didn’t try to hide it.” This is consistent with my face-to-face interaction with Mrs. Higgins when she addressed me in a confrontational manner.

On 1/31/25, I interviewed Guardian A by phone. Guardian A reported Resident A has a history of “claiming abuse,” meaning she interprets redirection that involves physical touch as abuse. However, Guardian A does not believe Mrs. Higgins abused or is abusing Resident A physically or emotionally. Guardian A reported Resident A does not like to be “managed.”

On 2/5/25, I interviewed adult protective service (APS) investigator, Annette Bearden. Ms. Bearden indicated she found no evidence of abuse or neglect, so her case was not substantiated.

On 2/26/25, I completed an exit conference with Mrs. Higgins. Mrs. Higgins maintains she moved Resident A from the area for her own safety. Mrs. Higgins argued, “This is ridiculous!” when I informed her that she cannot physically manage residents without relevant training in nonviolent crisis intervention to be authorized in writing in the treatment plan. Mrs. Higgins reasoned Resident A is mentally ill, therefore, she can’t make sound decisions on her own, including violating HIPPA laws by sharing Resident B’s medical crisis. In addition, Mrs. Higgins disagreed that she restricted Resident A’s movement by forcing her to go to her bedroom although the resident clearly didn’t want to go.

APPLICABLE RULE	
R 400.14308	**Resident behavior interventions prohibitions.**
	(2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: **(a) Use any form of punishment.** **(b) Use any form of physical force other than physical restraint as defined in these rules.** **(c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident.** **(d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner.** **(e) Withhold food, water, clothing, rest, or toilet use.**

	(f) Subject a resident to any of the following: **(i) Mental or emotional cruelty.** **(ii) Verbal abuse.** **(iii) Derogatory remarks about the resident or members of his or her family.** **(iv) Threats.** **(g) Refuse the resident entrance to the home.** **(h) Isolation of a resident as defined in R 400.14102(1)(m).** **(i) Any electrical shock device.**
ANALYSIS:	By her own admission, Mrs. Higgins physically managed Resident A by holding the resident's arm against her will to usher her towards the bedroom. Based on Resident A's statements and Mrs. Higgins' interactions with the police and myself being confrontational, there is a preponderance of evidence that Mrs. Higgins did use physical force with Resident A on 12/30/24 and subjected the resident to emotional cruelty by often bossing her around.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: There is no landline phone available, and the residents do not have access to cell phones to call for help in cases of emergency.

INVESTIGATION: On 1/14/25 and 1/31/25, I dialed the facility number listed in the bureau information tracking system. The number is recorded as (313) 218-3365. However, I received an ongoing message that "the service you're trying to use is restricted or unavailable." On 1/14/25, I asked Mrs. Higgin to verify the facility number, and she told me the number was correct. On 1/31/25, I followed up with Mrs. Higgins about the facility number and her response was dismissive. Mrs. Higgins stated, "Well, that's the number," then she changed the subject to discuss the assessments plans I requested.

On 2/24/25, I received an additional allegation that there is "no emergency phone" at the facility for resident use.

On 2/26/25, I completed an exit conference with Mrs. Higgins. Mrs. Higgins acknowledged there is no landline at the facility. Mrs. Higgins reported residents have access to a cell phone at the facility. Per Mrs. Higgins, family members and support specialists can contact the residents on this phone. Mrs. Higgins also acknowledged "the phone was broken" in recent months. Mrs. Higgins maintained there has always been a phone available at the facility. I asked Mrs. Higgins to provide the current facility number, and she responded, "I don't know it by heart."

Mrs. Higgins agreed to forward the number once the phone was charged. Approximately 3 hours later, I received a text message from Mrs. Higgins. The facility number she provided at that time is (313) 942-8463. To verify it is a working number, I dialed the latest phone number provided. The phone rang, but no one answered.

APPLICABLE RULE	
R 400.14318	**Emergency preparedness; evacuation plan; emergency transportation.**
	(3) A telephone shall be available and accessible in a home. Emergency telephone numbers shall, at a minimum, include fire, police, and medical emergency services and shall be conspicuously posted immediately adjacent to telephones.
ANALYSIS:	Mrs. Higgins failed to demonstrate a telephone has been consistently available at the facility. The most recent number provided is different than the number we have on record. Mrs. Higgins had to charge the phone just to get the phone number which demonstrates the phone was not fully functioning to send and receive calls. Also, Mrs. Higgins admitted the phone was broken in recent months.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Home has bed bugs.

INVESTIGATION: On 1/24/25, I received a phone call from Ms. Bearden with APS. Ms. Bearden reported she investigated the home for bed bugs. Ms. Bearden confirmed there is evidence of bed bugs at the facility.

On 1/31/25, I made a follow up call to Mrs. Higgins. Mrs. Higgins confirmed the home recently had bed bugs, but she has since treated the home to eradicate the problem. Mrs. Higgins blamed the bed bug problem on Resident A stating Resident A's visitors may have brought them into the home. Mrs. Higgins reported she purchased new mattress covers, MGK Crossfire Bed Bug Concentrate, and Hot Shot Bed Bug Killer to treat the home. Also, Guardian A supplied the home with a UV bed bug light to help rid the home of bed bugs. According to Mrs. Higgins, the bugs

were primarily concentrated in Resident A's bedroom. Both Resident A and B were observed by staff with bite marks. To date, Mrs. Higgins stated the bugs are gone. Direct care staff, Tequina Moore reported she observed a bed bug on Resident A's bed. Ms. Moore confirmed Mrs. Higgins took swift action to rid the home of bed bugs. Ms. Moore said she completes visual checks of the premises, and she hasn't seen any bed bugs sightings in weeks.

APPLICABLE RULE	
R 400.14401	**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:	Mrs. Higgins doesn't deny the allegation, but it appears the problem may be isolated to situational influences. Mrs. Higgins implemented her own pest control program to rid the home of bed bugs once she became aware of the problem. There have been no recent sightings or complaints of bed bugs. Therefore, Mrs. Higgins' eradication efforts have seemingly proven successful.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION: On 1/14/25, I completed an unannounced onsite inspection at the facility. I verified the home's licensed capacity is 3. However, I observed 4 residents in care. Mrs. Higgins reported that Resident B is "a respite client," so Resident B lives between the facility and a family member's home. However, respite admissions are included in the licensed capacity. I observed all 3 bedrooms, and although they're supposed to be all private rooms, I observed 2 beds in 1 of 3 rooms. There are 2 beds in Resident A's bedroom.

On 2/26/25, I completed an exit conference with Mrs. Higgins. Mrs. Higgins did not contest the investigative findings. Mrs. Higgins acknowledged Resident B is "extra."

APPLICABLE RULE	
R 400.14105	**Licensed capacity.**
	(1) The number of residents cared for in a home and the number of resident beds shall not be more than the capacity that is authorized by the license.

ANALYSIS:	The home is licensed to care for 3 residents; however, on 1/14/25, I observed 4 residents in care. An extra bed had been placed in 1 of 3 bedrooms. Mrs. Higgins acknowledged Resident B is "extra." Therefore, Mrs. Higgins exceeded the licensed capacity that is authorized by the license.
CONCLUSION:	**VIOLATION ESTABLISHED**

INVESTIGATION: On 1/14/25, I observed 4 vulnerable adults in care. Resident C was sitting in a wheelchair in the living room. I requested a copy of Resident C's most recent assessment plan. Therapist, Sarah Brookins provided me with a copy of Resident C's Integrated BioPsychosocial Assessment from Lincoln Behavioral Services dated 7/18/23. It is well documented that Resident C requires the regular use of a wheelchair. On 1/31/25, I interviewed Ms. Brookins by phone. Ms. Brookins reported she's only seen Resident C in a wheelchair when he comes to her office for therapy sessions. Direct care staff, Nehemiah Barnes and Tequina Moore reported Resident C can walk with assistance, but he prefers to use a wheelchair. On 2/7/25, I interviewed Guardian C by phone. Guardian C indicated Resident C "has not been able to walk since forever … It's been about 10 years since he last walked." Guardian C explained doctors confirmed that Resident C will likely not ever walk again because "his brain can't properly communicate with his legs." Guardian C said Resident C suffered neurological damage to the cranium as a result of being a professional boxer in his early years.

On 2/26/25, I completed an exit conference with Mrs. Higgins. Mrs. Higgins reported Resident C has been in her care for many years. Mrs. Higgins did not deny Resident C uses a wheelchair; however, she insists the resident can "ambulate 50% of the time" which does not align with the other witness statements or his assessment plan. I reminded Mrs. Higgins that her home is not approved to accept residents who require the regular use of a wheelchair. Based on my observation of the home, it is not equipped with wheelchair ramps at either means of egress.

APPLICABLE RULE	
R 400.14301	**Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal.**
	(2) A licensee shall not accept or retain a resident for care unless and until the licensee has completed a written assessment of the resident and determined that the resident is suitable pursuant to all of the following provisions:

	(b) The kinds of services, skills, and physical accommodations that are required of the home to meet the resident's needs are available in the home.
ANALYSIS:	Mrs. Higgins accepted and retained a resident in care who requires the regular use of a wheelchair. The home is not wheelchair accessible. Therefore, Mrs. Higgins allowed Resident C to remain in the home without meeting the needs of his physical accommodations.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Overall, Mrs. Higgins demonstrates a lack of willingness to comply with the licensing rules. Mrs. Higgins repeatedly minimized the violations. I informed Mrs. Higgins that her actions were harmful and placed the residents at substantial risk of harm.

Contingent upon receipt of an acceptable corrective action plan, I recommend the license be modified to a 1st provisional.

03/11/25

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K. Robinson Date
Licensing Consultant

Approved By:

03/11/2025

_____

Ardra Hunter Date
Area Manager