RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

SHELLY EDGERTON
DIRECTOR

March 26, 2018

Charles Udanoh
Angel Care Homes Inc
16565 Sunderland Road
Detroit, MI 48219

RE: License #: AS820299055
Investigation #: **2018A0992024**
Cherry AFC Home

Dear Mr. Udanoh:

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.

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,

Denasha Walker, Licensing Consultant
Bureau of Community and Health Systems
Cadillac Pl. Ste 9-100
3026 W. Grand Blvd
Detroit, MI 48202
(313) 300-9922

Enclosure

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

I. IDENTIFYING INFORMATION

License #:	AS820299055
Investigation #:	2018A0992024
Complaint Receipt Date:	02/09/2018
Investigation Initiation Date:	02/09/2018
Report Due Date:	04/10/2018
Licensee Name:	Angel Care Homes Inc
Licensee Address:	16565 Sunderland Road Detroit, MI 48219
Licensee Telephone #:	(313) 387-6042
Administrator:	Charles Udanoh
Licensee Designee:	Charles Udanoh
Name of Facility:	Cherry AFC Home
Facility Address:	30214 Cherry Avenue Romulus, MI 48174
Facility Telephone #:	(734) 941-4033
Original Issuance Date:	10/15/2009
License Status:	REGULAR
Effective Date:	03/23/2017
Expiration Date:	03/22/2019
Capacity:	6

Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED

ALLEGATION(S)

	Violation Established?
Per the incident report, Resident A accidentally took Resident B's medications while Moriam Sulaimon (staff) prepared breakfast.	Yes

II. METHODOLOGY

02/09/2018	Special Investigation Intake 2018A0992024
02/09/2018	Special Investigation Initiated - Telephone Interviewed Charles Udanoh, licensee designee.
02/13/2018	Contact - Face to Face Blandine Banedne, direct care staff and Resident A.
03/01/2018	Contact - Telephone call made I attempted telephone contact with Moriam Sulaimon, direct care staff (DCS). She was not available, message left.
03/01/2018	Contact - Telephone call made Mr. Udanoh
03/19/2018	Contact - Telephone call made Ms. Sulaimon
03/19/2018	Exit Conference Mr. Udanoh

ALLEGATION: Per the incident report, Resident A accidentally took Resident B's medications while Moriam Sulaimon (staff) prepared breakfast.

INVESTIGATION:

On 2/9/2018, I made telephone contact with Charles Udanoh, licensee designee, regarding the allegations. Mr. Udanoh said while Moriam Sulaimon, direct care staff

(DCS) was administering medications, Resident A accidentally took Resident B's medication. Mr. Udanoh said Resident A was monitored by the DCS following the reported incident. He said Resident A was not examined by a medical professional following the reported incident.

On 2/13/2018, I made an unannounced onsite. I interviewed Blandine Banedine, DCS and Resident A. Ms. Banedine said she was not onsite when the reported incident occurred but stated that she was previously made aware of the allegations. Ms. Banedine said Resident A took two of the wrong pills, that did not belong to her. She Resident A did not go to the doctor regarding that incident, but she went last Monday, for something unrelated. Ms. Banedine assimilated a medication pass and referenced the "five rights of medication administration." Ms. Banedine said the medications are always kept locked and not accessible to the Residents. Ms. Banedine said there is a protocol in the home if there is a medication error and a Resident consumes another Residents medication. She said the protocol is to call the licensee, call 911 and complete an incident report. Ms. Banedine said Ms. Sulaimon worked by herself on the day in question, she said staff work alone on their shift.

Resident A stated someone gave me the wrong medications. She was unable to provide any additional information pertaining to the allegations.

I reviewed Resident A and B's medication administration records (MARs). There was a line drawn through all Resident A's a.m. medications on 1/17/2018. The medications were as follows: CARVEDILOL 25mg PO TAB, take 1 tablet twice daily with food; BENZTROPINE MESYLATE 1mg PO TAB, take 1 tablet by mouth twice daily; HALOPERDIOL 10mg PO TAB, take 1 tablet by mouth twice daily; amlodipine BESYLATE 10mg PO TAB, take 1 tablet by mouth once daily; HYDROCHLOROTH/LISINOPR 12.5mg PO TAB, take 2 tablets by mouth once daily and TAB-VITE/IRON PO TAB, take 1 tablet by mouth once daily.

There were no discrepancies with Resident B's MARs.

I observed medication cups labeled with resident's names. Medications are kept in the cabinet and medication section.

On 3/19/2018, I made telephone contact with Ms. Sulaimon regarding the allegations. Ms. Sulaimon said on the day in question, she was in the process of administering medication. She said the home uses bubble packs, so she punched the bubble packs and placed Resident B's medication in the cup. She said she initialed the MARs and initialed and dated the bubble pack as well. She said Resident B said she wanted to take her medication after she ate breakfast and she asked for an extra piece of toast. Ms. Sulaimon said she made Resident B a piece of toast and when she went to give Resident A her medication, she said she had taken it already. Ms. Sulaimon said it was determined that Resident B placed her medication on the cabinet while waiting on her toast and Resident A accidentally

took it. She immediately made Mr. Udanoh aware of the incident. Ms. Sulaimon said at the time of the incident, she was relatively new to that home and was not used to working with six Residents. She said she recognizes her errors and has since received additional training.

On 3/19/2018, I conducted an exit conference with Mr. Udanoh and made him aware of the investigative findings. I expressed the need for a corrective action plan (CAP) to outline how compliance will be achieved, monitored and maintained; Mr. Udanoh agreed to complete the CAP.

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(4) When a licensee, administrator, or direct care staff member supervises the taking of medication by a resident, he or she shall comply with all of the following provisions: **(a) Be trained in the proper handling and administration of medication.** **(b) Complete an individual medication log that contains all of the following information:** **(i) The medication.** **(ii) The dosage.** **(iii) Label instructions for use.** **(iv) Time to be administered.** **(v) The initials of the person who administers the medication, which shall be entered at the time the medication is given.** **(vi) A resident's refusal to accept prescribed medication or procedures.** **(c) Record the reason for each administration of medication that is prescribed on an as needed basis.** **(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as needed basis. The review process shall include the resident's prescribing physician, the resident or his or her designated representative, and the responsible agency.** **(e) Not adjust or modify a resident's prescription medication without instructions from a physician or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record, in writing, any instructions regarding a resident's prescription medication.** **(f) Contact the appropriate health care professional if a medication error occurs or when a resident refuses prescribed medication or procedures and follow and record**

	the instructions given.
ANALYSIS:	During this investigation, I interviewed Charles Udanoh, licensee designee; Resident A; Blandine Banedne and Moriam Sulaimon, direct care staff. Based on the investigative findings, there is sufficient evidence that Moriam Sulaimon did not comply with initialing the medication administration records at the time the medication was given. In addition, she did not supervise Resident A and/or B while taking their medication. This investigation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 400.14312	**Resident medications.**
	(6) A licensee shall take reasonable precautions to insure that prescription medication is not used by a person other than the resident for whom the medication was prescribed.
ANALYSIS:	During this investigation, Moriam Sulaimon did not supervise Resident A and/or B while taking their medication. Resident B placed her medication on the counter, leaving the medication unlocked and accessible to other Residents. This investigation is substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

III. RECOMMENDATION

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

3/19/18

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Denasha Walker Date
Licensing Consultant

Approved By:

3/26/18

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Ardra Hunter Date
Area Manager