



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

November 9, 2021

Nakia Woods
Iyana's A.F.C. INC.
1117 Adams
Saginaw, MI 48602

| | |
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| RE: License #: | AS730398654 |
| Investigation #: | 2021A0123044 Iyana's A.F.C. INC. |

Dear Ms. Woods:

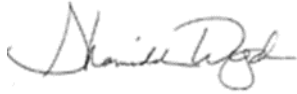
Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- 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 (906) 226-4171.

Sincerely,

A handwritten signature in cursive script, appearing to read "Shamidah Wyden".

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

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|---------------------------------------|---|
| License #: | AS730398654 |
| Investigation #: | 2021A0123044 |
| Complaint Receipt Date: | 09/22/2021 |
| Investigation Initiation Date: | 09/22/2021 |
| Report Due Date: | 11/21/2021 |
| Licensee Name: | Iyana's A.F.C. INC. |
| Licensee Address: | 1117 Adams Saginaw, MI 48602 |
| Licensee Telephone #: | (989) 332-4130 |
| Administrator: | Nakia Woods |
| Licensee Designee: | Nakia Woods |
| Name of Facility: | Iyana's A.F.C. INC. |
| Facility Address: | 1117 Adams Saginaw, MI 48602 |
| Facility Telephone #: | (989) 980-7899 |
| Original Issuance Date: | 08/13/2020 |
| License Status: | REGULAR |
| Effective Date: | 02/13/2021 |
| Expiration Date: | 02/12/2023 |
| Capacity: | 6 |
| Program Type: | PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL TRAUMATICALLY BRAIN INJURED ALZHEIMERS AGED |

II. ALLEGATION(S)

| | Violation Established? |
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| On 09/20/2021, Resident A was getting paid to do some work for the AFC owner's husband. Resident A was left alone with another person, at a home by themselves for six hours with no bathroom. Resident A was unable to hold her feces and went to the bathroom in her pants. | Yes |
| Additional Findings | Yes |

III. METHODOLOGY

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| 09/22/2021 | Special Investigation Intake 2021A0123044 |
| 09/22/2021 | Special Investigation Initiated - Telephone I spoke with Complainant 1 via phone. |
| 09/22/2021 | APS Referral Information received regarding APS referral. |
| 09/28/2021 | Inspection Completed On-site I conducted an unannounced visit at the facility. |
| 09/29/2021 | Contact - Telephone call received I received a call from Ms. Nakia Woods. |
| 09/30/2021 | Inspection Completed On-site I conducted a follow up visit and interviewed staff and Resident B. |
| 10/08/2021 | Contact- Telephone call made I left a voicemail for Resident B's case manager, requesting a return call. |
| 10/26/2021 | Exit Conference I spoke with Ms. Woods via phone. |
| 10/26/2021 | Contact- Telephone call made I left a second voicemail requesting a return call from Resident B's case manager. |

ALLEGATION: On 09/20/2021, Resident A was getting paid to do some work for the AFC owner's husband. Resident A was left alone with another person, at a home by themselves for six hours with no bathroom. Resident A was unable to hold her feces and went to the bathroom in her pants.

INVESTIGATION: On 09/22/2021, I spoke with Complainant 1 via phone and Complainant 1 stated the following:

The name of the other person who was working with Resident A is unknown. Resident A moved into the facility the beginning of September 2021. Resident A is physically capable of doing work and can be in the community on her own. The location of the property Resident A has been working at is unknown but is near a party store that also did not have a restroom. It is unknown how much Resident A was paid, but Resident A did report being compensated. Resident A is independent with toileting, and Resident A has not made any other complaints about the home. The licensee designee's husband (Mr. John Shabazz) felt bad about the incident and said it would not happen again.

On 09/28/2021, I conducted an unannounced on-site visit at the facility. I interviewed staff Evelyn Hanserd and Resident A.

Resident A stated that she was doing drywall and siding at a different house for Mr. John Shabazz. She stated that she was compensated \$25 the first time for six hours of work, \$15 the second time for six hours, and \$10 the third time for three hours of work. Resident A stated that she had a bowel movement on herself while at the other house. She stated that she is not sure if she is incontinent, and that these issues just started happening. She stated that she thinks it is due to her drinking regular Coke and not diet Coke. Resident A and Staff Hanserd stated that Resident A had an incident twice while working at Mr. Shabazz's other property. Staff Hanserd stated that the residents, Resident A and Resident B both work at the other property for about three hours at a time. Resident A stated that the property did not have running water, as they have just started fixing it up. She stated that she asked Mr. Shabazz if they were going to go back to the property, and Mr. Shabazz told her no, if she is going to be having bowel movements. She stated that Mr. Shabazz "jokingly" told her to go out into the woods to relieve herself. Resident A stated that the first time she worked, it was for six hours, and she did not have any accidents. The second time they worked for about six hours, and the third time it was about three hours. The second trip to the property she did have an accident. She stated that she had went next door to a neighbor's house to use their bathroom to urinate, and when she got back to the property owned by Mr. Shabazz, she had a bowel movement on herself. She stated that Mr. Shabazz was not present at the property with them at that time. She stated that she can go out into the community on her own, that she has no guardian, and no limitations. She stated that the third time she went to the property, she accidentally had a bowel movement on herself.

On 09/29/2021, I spoke with licensee designee Nakia Woods via phone. Ms. Woods stated that she has not gotten the full story about what happened. She stated that there is no working bathroom at the property Mr. Shabazz owns. She stated that Resident A has incontinence issues, and this was discussed when Resident A moved into the facility. She stated that Mr. Shabazz said that Resident A did not come to him and said anything happened. She stated that there are no issues as far as Resident A communicating her needs, and that Mr. Shabazz said that he did not leave the job site. She stated that Resident A went to the doctor about her incontinence issues a couple of days ago, and that the bowel movement incidents are a new issue. She stated that Resident A is high functioning and gets to her doctor appointments on her own. Ms. Woods stated that Mr. Shabazz is a trained staff person but does not think he was aware of Resident A's incontinence issues. She stated that she was told Mr. Shabazz was not paying Resident A and Resident B to do the work. She stated that she had provided Resident A with pads (to use in chairs when she sits down) and offered Resident A briefs.

On 09/30/2021, I conducted a scheduled visit at the facility. I spoke with Ms. Woods in person at the facility. She stated that Resident A did have a bowel movement on herself, and that Resident A told her that she and Resident B were left alone at the property. She stated that she thinks the incident with Resident A having a bowel movement on herself happened the day they were at the property but is not sure. She stated that a staff person called her and told her about the incident, but she does not recall the specific day. Ms. Woods stated that Resident B has no issues with his ADL's and is independent with personal care.

I reviewed Resident B's assessment plan during this on-site, and it states that he is capable of being in the community on his own. A copy of Resident A's assessment plan was obtained. Her assessment plan also indicates the ability to be in the community on her own with no staff assistance.

I interviewed staff John Shabazz at the facility. Mr. Shabazz denied the allegations. He stated that he took Resident A and Resident B for a ride to go and check on the other property. They parked, got out of the car, and checked the home for any possible vandalism. He stated that he went into the backyard to check the premises, and then they left. He denied that Resident A had been getting paid for painting the house. He denied leaving Resident A and Resident B at the property for six hours with no bathroom. He denied paying Resident A and Resident B saying the residents did not perform any work. He stated that he left the residents by themselves, and he denied that Resident A had a bowel movement on herself. He stated that Resident A never said anything about needing to use the bathroom. He stated that Resident A has told him that she can do a lot of work, but she has not demonstrated so.

On 09/30/2021, I interviewed Resident B at the facility. Resident B stated that he is his own person and has no guardian. Resident B stated that Mr. Shabazz's other property is a day care. He stated that he did do work at the property, including throwing sticks in a barrel, light drywalling, sweeping, chopping trees, and picking up

nails off the floor. He stated that he also learned to use a drill. He stated that he witnessed Resident A and Mr. Shabazz put up siding around a window, and that he and Resident A got paid for their work. He stated that he cannot remember how much they got paid, but one time it was about \$20, and he and Resident A split the money. He stated that the money they were compensated was enough for the job, and they worked from about 3:00 pm to 7:00 pm. He then stated that he and Resident A were not at the property long, maybe less than an hour. He stated that Resident A kept telling him that her stomach hurt, and that Resident A ended up pooping on herself, then sat on some steps. Resident B stated that they stayed at the property while Mr. Shabazz had left. She stated that Resident A used his phone to call Mr. Shabazz and Ms. Woods and told them to bring her something to clean herself up with. Resident B stated that they have been at the other property about four or five times. Resident B stated that there was no bathroom at the house they were working on, and Resident A had gone to the neighbor's house to use the bathroom. He stated that he should have gone with Resident A to the neighbor's house but was afraid to. Resident B stated that Mr. Shabazz picked them up and took them back to the facility.

On 09/30/2021, I re-interviewed staff Evelyn Hanserd at the facility. She stated that Resident A, Resident B, Ms. Woods, and Mr. Shabazz all stated that the residents have done work at the other property. She stated that Resident A said she was putting up drywall and taking out trash. She stated that Resident A told Mr. Shabazz that she knew how to do drywall, and that Resident A was going to show Resident B how to do things. Staff Hanserd denied having any knowledge regarding any payments to Resident A and Resident B, but that they have worked at the other property about four times. Staff Hanserd stated that she was at the facility working that day when Resident A reported she went to the neighbor's house to urinate, and then had a bowel movement in her pants. Staff Hanserd stated that she got a call that Mr. Shabazz needed to come and get Resident A some clothes to take back to Resident A. She stated that Mr. Shabazz said it was too much work, so he stopped taking Resident A and Resident B to the other property to work.

On 09/30/2021, after interviewing Staff Hanserd, I spoke with Ms. Woods outside of the facility. She admitted that Mr. Shabazz was not being truthful during his interview.

On 10/08/2021 and 10/26/2021, attempts were made to contact Resident B's case manager.

| APPLICABLE RULE | |
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| 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. |

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| ANALYSIS: | <p>Complainant 1, Resident A, Resident B, Staff Hanserd, and Ms. Woods reported that Resident A and Resident B were doing work for Mr. Shabazz, and that Resident A accidentally had a bowel movement on herself while working due to the worksite not having an available bathroom.</p> <p>Mr. Shabazz denied the allegations.</p> <p>There is a preponderance of evidence to substantiate a rule violation in regard to personal needs being attended to at all times. Resident A was left unattended at property that did not have a working bathroom, which resulted in her defecating on herself. Resident A was known to have incontinence issues at the time of her admittance into the facility.</p> |
| CONCLUSION: | VIOLATION ESTABLISHED |

ADDITIONAL FINDINGS:

INVESTIGATION: On 09/29/2021, I conducted a telephone call with licensee designee Nakia Woods. Ms. Woods reported that she has no health care appraisal on file for Resident A.

| APPLICABLE RULE | |
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| R 400.14301 | Resident admission criteria; resident assessment plan; emergency admission; resident care agreement; physician's instructions; health care appraisal. |
| | (10) At the time of the resident's admission to the home, a licensee shall require that the resident or the resident's designated representative provide a written health care appraisal that is completed within the 90-day period before the resident's admission to the home. A written health care appraisal shall be completed at least annually. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be obtained not later than 30 days after admission. A department health care appraisal form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department. |
| ANALYSIS: | <p>During this investigation, licensee designee Nakia Woods reported that she did not obtain a health care appraisal for Resident A within 90 days of Resident A's admission to the home and did not have one on file as of 09/29/2021.</p> <p>There is a preponderance of evidence to substantiate a rule</p> |

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| | violation. |
| CONCLUSION: | VIOLATION ESTABLISHED |

ADDITIONAL FINDINGS:

INVESTIGATION: On 09/30/2021, I obtained a copy of Resident A's assessment plan. The assessment plan does not detail any work performed by Resident A. Under section *IV. Social and Program Activities*, the *E. Workshop or Job* box is checked no, and there's no explanation of how this activity will be provided or encouraged. Resident B's assessment plan was reviewed as well. It does not indicate that he attends a workshop or job.

| APPLICABLE RULE | |
|------------------------|---|
| R 400.14305 | Resident protection. |
| | (2) All work that is performed by a resident shall be in accordance with the written assessment plan. |
| ANALYSIS: | On 09/30/2021, I obtained a copy of Resident A's assessment plan. Resident A's assessment plan did not detail any work performed by Resident A. There is a preponderance of evidence to substantiate a rule violation. |
| CONCLUSION: | VIOLATION ESTABLISHED |

INVESTIGATION: On 09/30/2021, I received a copy of Resident A's Resident Funds Part II form. There was no cash or AFC cost of care financial transactions documented on the form. A copy of Resident B's Funds Part II form was reviewed as well. His cost of care payments are documented, but no payments received for any work he conducted is documented.

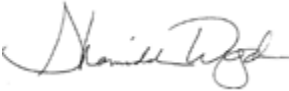
| APPLICABLE RULE | |
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| R 400.14315 | Handling of resident funds and valuables. |
| | (3) A licensee shall have a resident's funds and valuables transaction form completed and on file for each resident. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department. |
| ANALYSIS: | On 09/30/2021, I received a copy of Resident A's Resident Funds Part II form. There was no cash or AFC cost of care financial transactions documented on the form on Resident A's Funds Part II form. Resident B's Funds Part II form did have his cost of care payments documented. |

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| | There is a preponderance of evidence to substantiate a rule violation. |
| CONCLUSION: | VIOLATION ESTABLISHED |

On 10/26/2021, I conducted an exit conference with licensee designee Nakia Woods via phone. I informed her of the findings and conclusions.

IV. RECOMMENDATION

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



11/09/2021

Shamidah Wyden
Licensing Consultant

Date

Approved By:



11/09/2021

Mary E Holton
Area Manager

Date